April 19, 2022

Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard Baltimore, MD 21244

RE: Request for Information - Access to Coverage and Care in Medicaid & CHIP

Dear Administrator Brooks-LaSure,

The Alliance of Community Health Plans (ACHP) appreciates the opportunity to engage with the Administration on ways to enhance access to coverage and care within Medicaid and the Children's Health Insurance Program (CHIP).

ACHP member companies are provider-aligned, non-profit health organizations that provide high-quality coverage and care to more than 22 million Americans across 36 states and D.C., with over 3.2 million Medicaid consumers served. Driven by the provider-aligned, community-driven model, ACHP member health plans maintain coverage options across all lines of business and provide a vital bridge to help patients seamlessly transition from Medicaid to a qualified health plan during the redetermination process. We look forward to continuing partnering with CMS to implement strategies to ensure continuity of care and improve access to coverage.

ACHP has identified key priorities pertaining to CMS' request for information to inform the Agency's comprehensive access strategy for Medicaid and CHIP enrollees through:

- Identifying barriers to enrollment in coverage;
- Strategies to maintain coverage; and
- Enhancing access to services and supports.

Objective 1: Identifying strategies to ensure that individuals eligible for Medicaid and CHIP are aware of coverage options and how to apply for and retain coverage.

ACHP endorses expanded outreach efforts to consumers, plans, providers and community organizations, as building and enhancing these partnerships are critical to sustain long-term coverage retention efforts. CMS should continue to support states' capacity building for no wrong door, real-time eligibility and plan selection. This is critically important for states relying on the federally facilitated marketplace.

More can be done to preserve continuity of care and coverage, particularly for states relying on this platform. Efforts to develop similar "no wrong door" infrastructure for the federally facilitated marketplace will allow people exiting Medicaid coverage to be more seamlessly assigned to plans when transitioning, allowing for continuity of coverage after the end of the Public Health Emergency. Likewise, people exiting commercial coverage for Medicaid due to a change in circumstances should be able to make seamless transitions to coverage

that allows for minimal disruption in access to care. Knowing an individual's past plan and providers is critical to avoiding disruption and is a tool that states and CMS can use to ensure continuity of care.

Further, family glitch issues are more easily addressed with real-time eligibility and enrollment because consumers can plan selection for themselves as well as for their children at the same time. Consumers need additional education and outreach to ensure that they are aware of their eligibility for subsidized coverage and can access resources to effectively enroll into appropriate coverage for their needs. CMS should consider providing funding to community-based organizations that could support consumer education and outreach efforts.

Objective 2: Strategies to ensure that beneficiaries are not inappropriately disenrolled and to minimize gaps in enrollment due to transitions between programs, especially during or immediately after the COVID-19 Public Health Emergency (PHE).

ACHP applauds efforts to initiate continuous enrollment for children up to the age of six and transitioning youth in a manner such as that proposed in the Oregon Section 1115 waiver renewal. Continuous eligibility keeps people covered, mitigates churn and allows members to access care without disruption. We have long championed access to coverage, and our member health companies are well-positioned to bridge care when families move between payers and coverage types.

Ensuring consumers have uninterrupted care and coverage is critical to reaching the goal of health equity. Due to the significant variability in the Medicaid and marketplace functionality in each state-based marketplace, increased alignment within this process would lead to a more favorable consumer experience.

ACHP is pleased to see CMS' efforts to demystify the process for consumers by centralizing communications and places where people can get enrollment assistance. Further efforts to allow state-to-state transfers of eligibility information would help individuals make coverage transitions more smoothly, particularly since so many people have relocated during the pandemic. Further, the onus to update contact information is on members and the likelihood of obtaining information by this method is inconsistent. Incorrect contact information undermines continuity of coverage. Currently, plans receive updated information from returned mail, USPS data and claims. We encourage CMS and states to grant plans the flexibility to update member demographics to mitigate unnecessary loss of coverage.

In response to CMS's reference to the Basic Health Program, we note that the use of the Basic Health Program is uncharted territory, as only two states -New York and Minnesota - have implemented a Basic Health Program to date. These two states had pre-ACA programs that were the predecessor to the Basic Health Program and were built on Medicaid expansion waivers. These programs had expanded coverage into what has now become marketplace coverage in all other states. Implementing a Basic Health Program in states that currently do not offer one presents a significant risk to the existing state exchange markets, removing a segment of the population that has received coverage in this market since 2014.

The timeline for states to establish and certify a Basic Health Program makes it an inelegant and potentially market disrupting tool that CMS should not look to for individuals who may transition off of Medicaid since the timing to implement will likely not align with the termination of the public health emergency and the initiation of redeterminations.

ACHP recommends that states not create an additional program such as a Basic Health Program, but rather focus on building mechanisms to leverage the coverage continuum that is in place in the most seamless way possible. The importance of continuity of care with existing plans and providers is critical for Medicaid members, since

Medicaid overwhelmingly serves women during childbearing years, children and adolescents with special needs, as well as individuals with mental health and substance use conditions.

Objective 4: CMS is interested in feedback about what new data sources, existing data sources (including Transformed Medicaid Statistical Information System [T-MSIS], Medicaid and CHIP Core Sets, and home and community-based services (HCBS) measure set), and additional analyses could be used to meaningfully monitor and encourage equitable access within Medicaid and CHIP programs.

ACHP maintains that state regulators are in the best position to determine the network adequacy standards that should apply to the insurance markets in states.

We are concerned that applying another set of standards or review at the federal level creates undue burden and complexity for the consumer. Furthermore, we are leery that additional federal standards may not be tailored appropriately to each state's unique market dynamics and availability of providers and provider types. Across all markets, we urge HHS to work with issuers and national accrediting organizations to develop flexible standards that can be adapted by states and consider the various ways that consumers access care.

We urge HHS to avoid rigid standards that rely on outdated time and distance measures, as such measures are not appropriate for many geographic areas and do not equate to more timely care for patients. Instead, access standards should incorporate metrics that demonstrate enrollees have prompt access to appropriate, high-quality care such as the ability to receive care within a reasonable timeframe and plan performance on quality and patient satisfaction measures. We also urge HHS to recognize the critical role of telehealth in broadening access to health services.

As HHS works to develop a network adequacy framework for the 2023 plan year, ACHP offers the following recommendations:

- HHS should leverage reviews already performed by state regulators and national accrediting organizations.
- The ability to access services using telehealth be factored into the network adequacy evaluation framework.
- Network adequacy standards should promote the ability of issuers to create plans that provide integrated care and recognize the convenience and increased access that enrollees experience when they are able to receive multiple services at one location. HHS should factor the availability of co-located services into the network adequacy evaluation framework. This would be especially beneficial with respect to the integration of mental and behavioral health services with physical health services.
- HHS should consider metrics other than time/distance standards to evaluate network adequacy such as: performance on validated quality and patient satisfaction metrics such as HEDIS and CAHPS, enrollees' ability to receive care within a reasonable timeframe, whether plans provide "24/7" access to clinical advice, and whether plans engage in active monitoring and activities to address health disparities.

Granting flexibility and deference to states in these areas is important. We have supported recent modifications to the regulations governing the grievance and appeals system to promote further alignment and uniformity between rules for Medicaid managed care, Medicare Advantage, private health insurance and group health plans.

Objective 5: Leveraging existing and new access standards to assure Medicaid and CHIP payments are sufficient to enlist enough providers to ensure that beneficiaries have adequate access to services that are comparable to the general population within the same geographic area and comparable across Medicaid and

CHIP beneficiary groups, delivery systems, and programs. Additionally, addressing provider types with historically low participation rates in Medicaid and CHIP programs (e.g., behavioral health, dental, etc.), and non-financial policies that could help reduce provider burden and promote provider participation.

ACHP recommends HHS establish requirements that promote more consistent and transparent documentation of the rate setting process. Most of the analysis, calculation and validation about actuarial soundness is solely between the state Medicaid Agency and the contracted state actuary. We recommend an increased level of transparency for managed care organizations in these processes.

There may need to be variation of rate assumptions consistent with the characteristics of different Medicaid eligibility groups and the programs in which those population are enrolled. This is particularly true for complex populations served under the Temporary Aid for Needy Families (TANF), Aged, Blind and Disabled (ABD), and Long-Term Services and Supports (LTSS) eligibility groups. We recommend that CMS allow states to incorporate appropriate risk charges that reflect various levels of risk across the populations served by Medicaid.

ACHP supports the proposal to review the Medicaid managed care rate setting framework to expand on generally accepted definitions of actuarial soundness to ensure rates are developed in a consistent manner across all managed care organizations. We are aligned with proposals to explore whether provider rates are sufficient to support managed care organizations with respect to the availability and timely access to services, adequate networks and coordination and continuity of care. Additionally, consideration of default rates for services transitioning from fee for service to plan managed benefits is helpful. For example, when a state carves in a new benefit, it typically institutes required rates for some period of time. This process lessens arguments between plans and providers and ensures those costs are built into plan rates.

ACHP has been a strong advocate of efforts to bring more transparency to the rate setting process, including requiring that states, when requesting CMS certification of a rate range, to document prior to the start of the rating period the rate range for each managed care organization by eligibility group. States using rate ranges in competitive bidding should be required to provide managed care organizations with approved rate ranges, detailed trends and historical cost data in advance of bidding, increasing the likelihood that bids will be more likely to result in actuarially sound rates.

Finally, we commend CMS' ongoing efforts to bring further transparency to the rate development process through the issuance of annual sub-regulatory guidance on rate submission and review.

We encourage CMS to incorporate activities that improve social determinants of health in medical loss ratio calculations, by allowing the cost of value-added benefits that target specific social determinants of health to be included in the numerator of Medicaid managed care organization medical loss ratio calculations. This would encourage more spending on items that would improve the health of the beneficiaries and lower overall program costs. The development of community partnerships and modifying value-added benefits to meet the social needs of members is key to improving the overall health of the Medicaid population.

Inconsistent screening/health risk assessment requirements can create provider burden. These types of screenings are critical, but over-regulation of how they are done creates undue burden for providers as they care for patients.

ACHP is committed to working with CMS to protect access to care and coverage for the millions of Medicaid enrollees facing the specter of coverage loss. We look forward to continued engagement and partnership with CMS

as the Agency crafts its access strategy. Please contact Nissa Shaffi, ACHP's Associate Director of Public Policy, at nshaffi@achp.org or (202) 524-7773, with any questions or if we can provide further information.

Sincerely,

Ceci Connolly
President and CEO, ACHP